Alliance Care (Dales Homes) Limited

Emberbrook

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Emberbrook is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. Emberbrook accommodates up to 68 people in one adapted building. The building is arranged into four units, over two floors each with their own lounge and dining rooms.

At the time of our unannounced inspection on 24 October 2018 there were 60 older people living at the home, many of whom were living with dementia.

There was not a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had been without a registered manager since December 2017. A new manager had commenced in post in August 2018 and was applying to become registered.

We last inspected Emberbook in July 2017 when we rated the service as Requires Improvement. This was because we found shortfalls in staff deployment, following the principals of the Mental Capacity Act, records and governance. There was a breach of Regulation 11 in relation to obtaining people's consent. Following that inspection, the provider sent us an action plan telling us how and when they planned to meet the regulations. We checked at this inspection whether or not they had followed their action plan and we found they had improved in some areas, but there were shortfalls in others.

The service had been without a registered manager since December 2017. A new manager had commenced in post, but resigned after four months. During the time without a registered manager the registered provider had failed to ensure there was robust management oversight of the service. This has resulted in a people receiving a level of service less than they should expect.

People were living in a service that had insufficient staff to care for them and risks to people were not always addressed or recorded in a way that gave guidance to staff. We also observed poor moving and handling practices. Medicines management processes did not follow good practice. Where people lived with dementia the environment was not adapted for their needs. There was a lack of signposting or aids to orientate people. The service was clean.

Although people's needs were assessed before moving into the service. People had care plans in place which gave detailed guidance in many areas of their care needs, but writing was very difficult to read and people's background histories had not been obtained to help staff get to know people.

People were cared for by staff who did not always show them respect or respond to them in a caring way.

People were not always given a choice of the meal they would like to eat, although we did see people were provided with sufficient food and drink.

Accidents and incidents were recorded but not routinely analysed and although staff knew what to do in the event of a concern of abuse, paperwork in relation to reporting concerns could not be found. People's consent was sought before care commenced. Although we found an improvement in ensure the principals of the MCA were followed, there was further work to be done.

People were cared for by staff who had been recruited through a robust process. Staff had received induction and training for their role, however regular supervision, including clinical supervision, did not always happen.

Records relating to the service prior to the manager's appointment were difficult to find. There was a lack of complaints and audit information. However, the manager could access information we requested of them on the day.

People had access to activities both within and external to the service. However, there was a lack of equal access to activities across the service.

People and staff were enabled to participate in the running of the service. Audits had commenced under the leadership of the manager. The manager had an evident desire to improve the service, the culture within the staff team and the approach of staff to help ensure people had good quality care. The manager worked in conjunction with external agencies in order to help them achieve this. In the event of an emergency people's care would continue uninterrupted.

During our inspection we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made five recommendations to the registered provider. You can read what action we have asked the registered provider to take in the main body of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

People's medicines were not managed in a safe way.

Risks to people were not always responded to and poor moving and handling practices were observed.

People were not always cared for by enough staff and where people had accidents or incidents these were not always analysed to look for trends.

People lived in an environment that was routinely cleaned.

Staff had been appointed through robust recruitment processes.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always follow the principals of the Mental Capacity Act 2005.

The environment was not always adapted for people's individual needs.

Staff were provided with training but they did not always have access to supervision.

People were provided with sufficient food and drink as well as support to access health care professionals when needed.

People's needs were assessed before moving in to Emberbrook.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always cared for by staff who showed them respect or attention. This was despite people telling us staff were kind to them.

Please were given the opportunity remain independent and they could make choices around their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had access to activities, although this was not consistent across the service.

People received appropriate end of life care, although some further detail in people's end of life care plans is recommended.

People's needs were responded to by staff.

There was a complaints procedure in place which ensured that people were listened to.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of good governance arrangements in place. We identified shortfalls in several aspects of the service as well as the way people's care plans were written.

Staff, people and relatives had the opportunity to feed into the service.

We received positive comments and feedback about the new manager. There was an obvious drive from the manager to improve the service that people received.

The manager worked in conjunction with external agencies.

Care Quality Commission

Emberbrook

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 24 October 2018 and was unannounced. This was a comprehensive inspection carried out by four inspectors and an expert by experience. An expert by experience has experience of caring for or knowing someone who has lived in this type of setting.

Before the inspection we reviewed the evidence we had about the service. This included any notifications of significant events, such as serious injuries or safeguarding referrals. Notifications are information about important events which the provider is required to send us by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This enabled us to ensure we were addressing potential areas of concern at our inspection.

We contacted social care professionals for their views of the service before we visited. We also spoke with one health care professional during the inspection.

During the inspection we spoke with eight people who lived at the home and five relatives. We also spoke with nine members of staff plus the registered manager and one of the provider's area managers. If people were unable to tell us directly about their experience, we observed the care they received and the interactions they had with staff. We looked at seven people's care records, including their assessments, care plans and risk assessments. We checked training records, three staff recruitment files and how medicines were managed. We also looked at health and safety checks, quality monitoring checks and the results of the provider's latest satisfaction surveys.

Requires Improvement

Is the service safe?

Our findings

People gave us positive comments about their safety and the staffing levels within the service. One person told us, "I feel quite safe being here." They added, "The staff are always there to help me. I only have to ring my bell and they come. They do seem overworked though." Another said, "I never have to lock the door or anything. When I need any help, they come to see me." A third told us, "Couldn't be safer anywhere else." However, despite these comments we identified some shortfalls within the service.

People were not always cared for by a sufficient number of staff who were deployed appropriately. One person said, "Sometimes a bit short during the day. Sometimes have to wait a bit longer." A relative told us, "Sometimes there are not enough staff. He's had lots of falls. He wanders all the time. He needs to be watched a bit more." A second relative said, "Staffing is an issue. Having a few problems at the moment." During the morning we observed people in one of the living areas. We found there were insufficient staff to ensure that they always knew where people were and as such we observed some people at risk as there was one person who had behaviours that challenged themselves and others. We spoke with the manager about the situation. They informed us that they were aware that one person may require closer supervision and as such discussions were taking place to determine whether or not Emberbrook was a suitable place for this person.

In another living area during lunch time we found some people waited for over 15 minutes for their meal, whilst others, who clearly needed support to eat, did not receive this. This resulted in one person eating a meal that was cold. A second person required regular attention from staff. As a result, this meant that a staff member was taken away from supporting others whilst they were attending to this person.

We found that in one that there were only three staff caring for 14 people, despite being told there should be four staff. Another living area, which was supposed to have three care staff, only had two. A staff member told us, "When it's lower (staffing levels), it's unexpected pressure." They added, "Mornings can be like this. Some people go in other people's rooms." A second member of staff told us, "We have so much to do." A third staff member said, "Night staff start the personal care for around six people and we will carry on what's not been done.". We received many more comments from staff members about the lack of staff numbers. Such as, "They (management) ask me to come in on my day off" and, "Some days in some units we are short-staffed, that happens about once a week. Agency don't get brought in – I don't know why." The manager told us they were aware that staffing numbers were an issue and as such they were filling rotas with agency staff were needed. In the meantime, there was an on-going recruitment campaign underway.

People did not always receive staff's attention due to staffing levels. At lunch time, in one living area, we saw a staff member assist a person to eat. However, the staff member was consistently interrupted by other people's needs. For example, at one point they stopped assisting the person they were helping to get up and make a cup of tea for another person. They were also heard several times addressing other people across the dining room because there were no other staff available. When one person selected their meal choice, it took staff five minutes to bring the person their meal as they were trying to complete other tasks in the meantime, such as taking meals to people in their rooms. Two people in one living area did not receive their

meal until 13:35, despite people having sat in the dining area since 13:00. We had identified some concerns at our last inspection around staff deployment and had made a recommendation to the registered provider.

The lack of appropriately deployed staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff identified risks to people they did not always act in a way that may reduce the risk for the person. For example, food and fluid charts for people at risk of malnutrition and dehydration were poorly written so they were difficult to read. There were also no totals for food and fluid intake of people which meant staff would not be able to easily identify if people were lacking the amount of food they required daily. In addition, we observed one person being moved by a hoist. We heard the person telling staff that they were uncomfortable and the senior staff member present commented that the person's sling had not been put on properly. Despite this, the senior staff member continued to move the person. This resulted in the person telling them, "I'm going to split in half" and telling us, after their ordeal, "It hurt me very much." Later we observed a second incident related to poor moving and handling procedures. Staff were struggling to get the sling under the person's body. No advice or assistance was given by the senior staff member. They started to lift the person but stopped and put them back down, causing the person to have the top of the sling over their head. They adjusted it again and the person started shouting, "Use your brains, talk to each other. It's very painful." The person looked uncomfortable with the sling over their head and their knees up near their face. The whole time the staff were talking to each other, but not the person. We reported these concerns back to the manager during our inspection in particular relating to the senior staff member. Following the inspection, the manager informed us were taking action to address this.

People's medicines were not always managed in a way that followed best practice despite receiving positive comments from people. One person told us, "I am happy about how my medicines are managed." Another said, "They bring the tablets. Always know when the tablets are due and always get them. If I'm in pain they give me some tablets." In one living area throughout the morning we observed a tin of thickening powder left in the dining room area and latterly on the top of the medicines trolley unattended. Although people did not appear to be at risk of picking it up and inadvertently ingesting it, the thickening powder was not being stored in line with an NHS England safety alert in 2015. This recommended that thickening powders should be stored securely, out of reach of people. We also observed a staff member administering medicines to people and not waiting to check they had taken them. We saw the staff member empty a pot of tablets on to the table in front of one person and walk away. The person took the medicines a few minutes after the staff member left. We then saw the staff member came back and tipped a pot of medicines next to another resident's plate and walked away without waiting for them to take them. We reviewed the medicines records of three of the four living areas and found some gaps in Medicine Administration Records for people and a lack of protocols for medicines prescribed PRN (as required). PRN protocols are important, particularly for people who may be living with dementia. The protocol details signs and indications that a person may display to show they are in pain; signs which they may not be able to verbalise. We also checked the first aid kits in two of the units and found numerous items in both that expired in 2014, 2015 and 2016.

Where people had accidents and incidents we found that staff responded appropriately but these were not always recorded and those that were recorded were not analysed to look for trends or themes. The manager told us that this was something they were instigating but they could not confirm whether the existing manager had carried out any analysis. One person had daily incidents and a high number of falls. We reviewed this person's care plan for any accidents they had had. We found that between 10 September and 22 October 2018, 23 incidents had occurred. Of those, 18 had not had an accident and incident report completed. We did hear however from people that staff responded when they had an accident. One person told us, "I had a fall here when I fell off a chair. They (staff) came straight away when I called out to them.

They rang for the ambulance." Furthermore, a staff member told us, "We always check someone if they have an accident. It it's serious then we will leave them in place until the paramedics get here."

The lack of good medicines management practices, responding to risks to people, poor moving and handling practices and recording accidents and incidents was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff who understood what they should do if they suspected abuse. However, we found some incidents had not be raised as safeguarding concerns. We were told by a family member, "The other day he (the family member) pushed a table over and he hit one of the ladies." We checked the incident, accident and safeguarding records and found this had not been recorded or reported. Another person's care plan recorded unexplained bruising on their arm and staff reporting a bruise and skin tear with the cause unknown and yet these had not been logged as potential safeguarding incidents. Again, however, records relating to incidents that occurred prior to the new manager commencing in post could not be found.

We recommend the registered provider ensures that any incidents of potential safeguarding are recorded as such and reported to the appropriate authorities.

We saw housekeeping staff working hard during the day in order to keep the environment clean. People told us that staff wore personal protective equipment. One person said, "I see the staff wearing gloves and aprons when they are washing me or anything like that." Another told us, "The cleaners work really hard." We found the laundry clean and well organised with a clear distinction between the clean and the dirty laundry.

In the event of an emergency people would be protected from their care being interrupted. There was a business continuity plan in place and a fire folder. This included a contact list and details of the 'grab' bag in the event of a fire or an emergency. The 'grab' bag held information relating to each person in terms of the support they may need to evacuate the building. We asked a staff member about the fire/emergency process and they were able to tell us what would happen. All fire safety equipment, drills and checks had been completed. In addition, water, window restrictor and call bells checks were carried out monthly to help ensure people lived in a safe environment. A staff member said, "We have fire training and drills every Tuesday."

People were cared for by staff who had been recruited through a robust recruitment process. We saw employment history, references, evidence of right to work in the UK, clinical qualifications and fitness to work were checked before prospective staff commenced at the service. In addition, a Disclosure and Barring Service (DBS) check was undertaken to help ensure they were suitable to work in this type of care setting. DBS checks help employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

At our inspection in July 2017 we found the service was not meeting the requirements of the Mental Capacity Act 2005 (MCA). At this inspection we found improvements had been made, but there was further work to be done.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether staff were meeting the requirements of the MCA and following its principals. We found that improvement had been made as capacity assessments had been carried out and DoLS applications submitted. However, we found in some cases that decision-specific capacity assessments were not always being carried out. For example, one person was prevented from leaving their locked living area, but there was no decision-specific capacity assessment or DoLS application for this. Another person had a DoLS application for their crash mat, 24-hour care and the locked door. This was not dated and was not accompanied by individual capacity assessments for each decision. A further person had all their decisions made on their behalf by their family member. There was a lack of evidence of other people/professionals being involved in these decisions. However, we did find where people were on covert medicines (medicines given without their knowledge) capacity assessments, best interests decisions and pharmacy and GP involvement was in place. A staff member told us, "I ask every time for consent for everything."

We recommend the registered provider ensures that where people lack capacity to make a specific decision, the principals of the Mental Capacity Act 2005 are followed.
Staff received training that was appropriate to their role. However, from our observations in relation to transferring people with a hoist, it was evident that refresher moving and handling training was needed. One person told us, "The staff are knowledgeable, they are responsive to what I request." A staff member told us, "We have all done our training and know what we are doing." Another said, "We have set training for us. We have had a lot." A professional said, "They (staff) are good with the training as the staff know what they are doing."
Staff supervision was undertaken; however, this was not done consistently and clinical staff did not receive clinical supervision. A staff member told us, "I have had supervision. It was useful. I now feel supported by management." A clinical member of staff told us, "We are doing all the (clinical) checks we need to. I had clinical supervisions with the deputy manager but she had moved on. I now check myself." The manager told us, "A lot of support has not been there, for example clinical competency is not being done at present."

We recommend the registered provider ensures staff receive the support, training and supervision necessary to enable them to carry out the duties they are employed to perform.

Adaptations around the service were limited, this was despite many people at the service living with dementia. We noted four doors in two of the units for people living with dementia had been painted to look like front doors, but the rest had not. There was a lack of memory boxes, or pictures identifying people's rooms to help with orientation, although we did see that the toilet and bathroom doors had pictures on them. We also noted the toilets had blue toilet seats on them to make them easily recognisable. Although the service advertised on their website, 'our home is set across four wings, each with its own dining room, large lounge area and a smaller quiet lounge' we found this not to be the case. We found one wing did not have a lounge area. A staff member told us, "We don't really have a lounge area with comfy sofas which is why everyone stays in their rooms." Another staff member said, "People are bored, but they don't want to leave their rooms." A relative told us, "I have to provide a high toilet seat for him as they (the service) said they couldn't provide one."
We recommend the registered provider ensures that the environment people live in is suitable for their needs.
We did find however that where people were at risk of pressure wounds, equipment had been provided for them. For example, we saw people had alternating pressure relieving mattresses in place. One person was at high risk of falls and we read they had been provided with a sensor mat to alert staff if they got out of bed.

We saw evidence of health care professionals' involvement in people's care plans, such as the GP, speech and language therapy team, podiatrist or mental health team. One person told us, "They get a doctor when I need a doctor." Another said, "A doctor comes frequently. I see him often and when I want to see him. There's always a dentist and optician to come and examine us." A health professional said, "I have never had to treat anyone here for injuries sustained due to bad care." A staff member told us, "We assist and support people to see all other medical professionals such as chiropodists, etc." Where professionals put guidance in place for staff, this was followed. We saw that a professional had asked staff to record someone's behaviour for a period of two weeks and we observed the records had been completed as required.

People were positive about the food they were provided with. One person told us, "I had eggs and bacon today and they were fine. You are asked what you want to eat the day before and they bring it." Another person said, "You get the food that you want." A third told us, "Very satisfactory; very good choice." People's dietary needs were met. We observed those people who required a soft or pureed diet received this. We also observed staff using thickener for those people who were at risk of choking.

People's needs were assessed prior to moving into the service. All aspects of a person's care needs were recorded in the assessments. Care plans were developed from people's pre-assessment information.

Requires Improvement

Is the service caring?

Our findings

People gave us positive feedback about the staff caring for them. One person said, "They (staff) are very good. The staff are caring and nice, they are all friendly." Another told us, "The nurse always comes to check you are okay. The staff are very nice; they are very kind." A third said, "It's fine. I'm very happy here. I like to be here – I have things in my room."

However, we found people were not always shown respect or attention by staff. We were shown someone's breakfast and saw that staff had just 'dolloped' jam on the person's bread without spreading it. The person was unable to hold bread and needed it lightly toasted, but this had not been done. We observed the lunch period was disorganised in two of the living areas. In one we saw the lunch trolley arrive in the dining room at 12:46, however by 13:25 only two people had been served their meal. We heard staff asking people, "Can I put a bib on" at lunch time which was not a respectful way of describing the clothes protector. During the morning, over the period of one hour, we sat in one wing and heard a CD playing. When the CD came to an end staff, without asking people, played it again.

Although staff told us they gave people choice, we did not find this to be the case. A staff member told us, "We ask them all the time as to what or how they want things done with regard to their care." Although we saw some people being offered their meals in a way that would support them to decide what they wished to eat, this was not consistent. This was despite a staff member telling us, "We ask them (people) what they want to eat. We show them pictures of the food so they can choose." We also found people were not asked where they would like to sit and meals were put down in front of people without staff describing them to people. This is particularly important for people living with dementia who may not be able to recognise the food on the plate. In one living area we saw one staff member showing people plated meals, however the other staff member did not do this. One person chose the steak pudding and the staff member left to get it for them. After five minutes the staff member returned with a pork dinner. The person said, "But I wanted the pie." The staff member said, "Do you want a sandwich instead, or just don't eat the meat (on the plate)." Another person was given the pork dish by a staff member without being asked what they wanted.

The way people were spoken to by some staff did not always display a person-centred, respectful approach. Much of what we observed related to one staff member only and we spoke with the manager about this at the end of our inspection. We heard this staff member discuss with a person whether they needed a laxative or not. This was done in the dining room in front of other people and then latterly when the person was in their room and the staff member in the corridor, which meant the staff member shouted loudly to them. One person suffered from anxiety. It was clear in their care plan that staff should try to help calm the person when they showed visible signs of agitation. However, we observed a staff member not following this guidance and as such they appeared to be impatient and irritated by the person's behaviour. This was despite this staff member telling us, "She needs reassurance." Another person was sitting with their back to staff and a staff member came into the room and called to another staff member, "Put her in her room after that." This same staff member was seen wheeling someone out of the lounge area to go to the hairdresser, but they had made no attempt to wake the person to let them know where they were taking them. We also saw a second person being wheeled in a wheelchair. Her skirt was above her knees meaning her underwear

could be seen. A person told us, pointing at the staff member, "She makes too much noise." A relative said, "[Name] is not approachable or particularly warm and friendly."

The odour of urine in six bedrooms meant that those people were living in an unpleasant atmosphere that no one would wish for their relatives and is undignified.

The lack of respect shown to people was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some staff members assist people in a kind and patient way by supporting them to eat and waiting for them to finish their mouthful before presenting them with the next. A staff member was seen walking with a person down the corridor. They were holding the person's hand chatting away to them. The person sat down then wanted to stand back up again and the staff member said, "Do you want to stay here or go to the lounge?" The person attempted to stand up again and the staff member commented, "One, two, three, up we go. Oh well done, that's nice." Another staff member noticed one person appeared uncomfortable in their wheelchair at lunch time. They asked them if they were okay and the person said they wished the footplates on their wheelchair put back down. This was done immediately.

People were encouraged to remain independent. We observed one person using a cup which was specially adapted to allow them to drink without assistance. One person said, "I can choose when, where and how I live each day here. In the summer I go out in the garden." Another told us, "There are lots of activities here that I don't want to take part in. I prefer my solitude." A third said, "I have multiple decreasing issues. They allow me to lead an independent life. I have a bunch of friends who come. I can organise my life." A staff member said, "We try to get them to do everything themselves first and then we only add a helping hand if necessary." A person told us, "You are left to do what you want to do. It's your choice."

People's privacy was respected and individual staff showed attention to people (apart from the instances detailed above). One person told us, "If I want my room door closed then they will close it so I can be by myself. I can watch TV alone in the evenings without any disturbance." Another said of staff, "Very polite and kind and knock on the door." One person had taken off their slippers and a staff member fetched socks for them, carefully putting them on to help ensure the person's feet stayed warm. They checked throughout that the person was happy with what they were doing.

Staff did appear to know people. One staff member was able to tell us about a person's previous job and the topics of conversation they enjoyed. They also told us how another person used to sing. One person became anxious and agitated and staff were quick to ask us to give them some room to relieve their anxiety. We saw that this had a positive effect on the person. A relative said, "They (staff) get to know the resident, they know each individual." They added, "As soon as I come in they ask what would I like to drink. Sometimes when I'm in the dining room they offer me something. Not just caring for residents, also their partners as well."

Requires Improvement

Is the service responsive?

Our findings

We found information in people's care plans lacked detail and the care plans were not person-centred. One person's care plan stated in their records relating to professional's visits, 'lying in bed'. This was dated from 12 July 2018 to 17 July 2018. There was no name of the professional or any other detail. A further entry recorded, 'foot and toenails appear very red, inflamed, infected?' Again, there was a lack of detail about the care in relation to this and progress in terms of improvement. One person's care plan was too big to be user-friendly and not arranged in a useful way to enable staff to access the really useful information. For example, the person's background history was half way through the folder and there was illegible handwriting throughout the care plan, so it was difficult to read what was needed. This person's nutritional assessment was very brief. It stated the person was overweight and needed to lose weight, but there was no guidance for staff on how they could support the person to do this. We noted in another person's care plan that although there was information from the previous place they had resided in this had not been transferred over. As a result, staff told us they were not sure Emberbrook was the right setting for this person. We spoke with the manager about this who told us they were looking at all options in order to help ensure this person could remain at the service. One person had had a fall which had resulted in a head wound. Despite this their falls risk assessment had not been updated and there was no wound care plan for the head injury to include photographs or evidence that this person was monitored after the fall. Another person had Parkinson's but there was no care plan in place for this which would help staff recognise or understanding how this condition would affect the person. A further person's nutrition care plan dated February 2018 recorded they were on a soft diet, however their daily food chart recorded they were on a 'normal' diet.

The lack of person-centred care planning was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, people told us they felt they got responsive care. One person said, "I have never had a pressure sore – my legs are massaged twice a day. I've only had one urine infection and don't get chest infections." We read one care plan where information around a person's feeding tube was very comprehensive. Information covered the cleaning regime, the food and safety requirements. Another person's care plan noted they, 'loves cat toy' and we saw them with this. We also found that people did receive responsive care. One person had an, 'un-gradable pressure sore on heel on admission'. There were photographs and a care plan in place. We noted the sore was healing. We also read a psychiatrist had noted that someone had, 'calmed since being at Emberbrook'. This same person was diabetic and had a diabetic retinal eye screening appointment.

A staff member said, "I refer to the care plans daily. They are very useful." Another told us, "Care plans are very useful here because everything is documented there. If you miss a day you can read over and get an update on what's happened. Doctors' notes, discussions, etc. it's all there." There was a daily 11am meeting for senior staff where they discussed people's needs or any changes required to people's care.

People's care plans in relation to their end of life wishes were limited although we did find some information. One person's care plan stated they were not religious, wished to be cremated and did not want

to go to hospital. A staff member said, "I have supported quite a few people towards the end of their lives. We call the hospice about the medicines needed and care when necessary." We observed in one person's care plan that the doctor had asked to be involved when they deteriorated.

People had access to activities and where people had individual interests these were recognised. However, we did not find this consistently across the service and in one living area the activities timetable displayed was not for the current week. One person told us, "The staff tell me if something is going to happen, like trips to Brighton or things like that. They always ask me if I want to go." Another person told us, "I play cards or listen to the radio after lunchtime." A third said, "I was out about three weeks ago – went to one of the garden centres." One person liked to cook. A staff member told us the person cooked soup sometimes. They said, "She cooks a lot and we let her do the whole thing herself as she likes to do it herself." A staff member told us, "We ask for people's wishes. One person said they wanted to go to Harrods, so we arranged a visit for them and others to the store one morning before it opened to the public. Another person is on end of life but they've always wanted to go in a helicopter. We are trying to organise it for them. A third person had done lots of research on Monkey World as they'd always wanted to go. We made the trip and they were so happy." A person told us, "Sometimes I go to the bingo – I enjoy that. Other times I watch TV. It's my choice." A health care professional said, "I have seen bingo, painting, yoga, Pilates. I think there are enough activities. Sometimes they are doing a lot of activities and I can't see people as a result." A staff member told us, "There's bingo, knitting, Pilates, yoga, art classes, and music time. Outside entertainers come in – like yesterday, we had an opera singer."

One person told us, "I am able to do what I want. I like to read, I have all of my books in my room with me and I read. Where people spent time in their room the activities staff told us they did one to one sessions with them which included, "Talking and sensory or touch interaction to try and stimulate them."

However, in one living area we did not see any activity taking place throughout the day. A relative told us, "I never know when activities are happening. There's nothing for him to do." In another living area, one staff member was trying to get people to join them in singing and another encouraging painting. However, other staff did not take the time to engage with people.

We recommend the registered provider ensures that there is a consistent approach for people to enable them to live a fulfilling life through participation in personal interests and hobbies.

Complaints information was available to people and their relatives. One person said, "I've never complained." Another told us, "If I had any problem I would speak to the main nurse." A relative said, "I would go straight to management.". Since the manager had commenced in role they had received three complaints. We read that these had been responded to appropriately with fully investigations and action taken.

Inadequate

Is the service well-led?

Our findings

At our inspection in July 2017 we rated this domain as Requires Improvement. This was because we found shortfalls in governance arrangements and care plans. However, we did not find the registered provider was breaching any regulations in relation to this. Although the manager had clearly identified the shortfalls in the service, they had had limited time to make any real positive impact and as such improvement was negligible.

In addition, there had been a lack of registered manager at the service since December 2017. A new manager had started at the service, but left after four months. In the meantime, the registered provider had not ensured there was robust management oversight of the service. This had contributed to the shortfalls we identified at this inspection. The manager, who commenced in August 2018, told us they had started the process of applying to become registered manager. This would help reinstate some stability to the service. One staff member told us, "He's supportive and helpful but needs more support from head office. He's trying his best."

The manager was aware of the shortfalls within the service and it was evident they had a desire to improve things. They told us, "I am aware of the need to improve. It's not that I'm not trying to address issues. I met our DoLS and MCA person. It's an area that has moved on, but I am aware it still needs work. Adaptation – I haven't got around to that yet – I know and accept there are some gaps." The manager told us, "I have a big hill to climb and at the moment I'm at the bottom of that. I'm sitting down and analysing everything. I've advertised for a deputy."

The culture within the staff team varied. The manager told us, "I plan to do sessions with staff going through the values and how to get person-centred care, get residents involved within the home. We already have someone involved with the garden and another who helps with the show-arounds."

There was a lack of auditing of the service. Although the manager gave us a folder of audits that had taken place prior to him commencing in the role, these were mainly tick box exercises with some not even dated. The manager had started his own audits, but as he had been in post for such a short period of time he had yet to complete a full review of everything. We noted a kitchen, tissue viability, recreation and activity, nutrition and hydration and health and safety audit had taken place. Although there were comments such as, 'night staff not updating percentages in relation to tissue damage', 'we have to fulfil all our residents' wishes' and, 'fire doors still awaiting replacement' there was no evidence that action had been taken or completed. We also found on the day that information relating to complaints received prior to the manager starting could not be found.

The provider's regional manager carried out a monthly visit. This resulted in a report given to the manager. The last visit was in August 2018, although the manager did not receive the outcome of the visit until October 2018. The visit covered audits, medicines, accidents, meetings, people's dining experience, staff training and health and safety. Although comments were recorded on the audit, there was no action plan as a result and no evidence that any shortfalls had been addressed. The manager told us following our

inspection that they were working on a service improvement plan, taking into account our feedback as well as the outcome of any audits.

Providers should be meeting the standards set out in the Health and Social Care Act 2014 regulations and displaying the characteristics of good care. However, we had identified shortfalls with staffing levels, medicines, risks to people, keeping people safe, showing respect to people, record keeping and following the principals of the MCA.

The lack of good governance within the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was good feedback from people about the manager. One person told us, "I think the home is well managed. I've never been troubled by anything." Another person said, "He's not here today. I've met him; he's very nice. I think he's a good manager. He seems to get things done around here." A third told us, "Yes, came and introduced himself. I'm sure if I had a problem I could go to him." A further person said, "He's only been here a few weeks. People are on his side. He has improved the atmosphere."

A staff member told us, "I like working here because the organisation is very homely. It's like a family. The manager is very attentive to us and is working to help us." Another said, "He's good. He's only just finding his feet. He is out and about. He interacts with the residents well. He hasn't been here that long but he knows most of their names." A second staff member told us, "[Manager] is nice. He's very approachable. He tries his best. We asked for glasses for the kitchen and he bought them for us within a couple of days. He comes and talks to us directly about changes. He introduced points and issues during the day." A third said, "The manager [name] is nice, he is a good man. He is trying to talk with us and if I have a problem he will listen to me and try to help me. He is trying to manage things here and improve things."

Professionals gave equally positive feedback. One professional told us, "The manager is a really nice guy. He is a lot more involved than the last manager. He is much more approachable and active. He's always actively going around and saying 'hello' to people. He doesn't sit in the office the whole time."

Staff were encouraged to participate in the running of the service. A staff member said, "We have a standard (handover) meeting at 11:00am in the manager's office for senior staff. The other staff meet every month. We made suggestions about changing the layout of bedrooms so that we could use the hoists better and more effectively. They changed and adapted the rooms following this." Staff were asked to complete a survey annually to feed back their views on working at the service. We read from the 2018 results that on the whole staff were happy working at Emberbrook.

Relatives told us they had the opportunity to attend meetings. One relative said, "Been to a meeting here. They are going to have them quarterly for the relatives. First one I've been to – it was enjoyable. They go through everything, and we put our opinions over what we think is good. The manager said we are always welcome to come and see him." Another relative told us, "The new manager seems really nice, I do hope he stays. You see him a lot genuinely concerned about the running of the place."

The manager was engaging with external agencies to help drive improvement within the service. They told us, "Surrey Downs Clinical Commissioning Group are delivering training and we work with the Princess Alice hospice. We also use the Care Home Pathway which involves working with distressed residents who have behaviours (that challenge them or others)."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure person-centred care planning was in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure people were always treated with respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured proper medicines management processes were in place, risks to people were responded to or accidents and incidents recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured sufficient numbers of staff were deployed at the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure good governance arrangements were in place.

The enforcement action we took:

We have issued a warning notice to the registered provider in respect of this Regulation. We have set timescales in which the registered provider must become compliant.